

Case Number:	CM14-0210109		
Date Assigned:	12/23/2014	Date of Injury:	07/06/2009
Decision Date:	02/17/2015	UR Denial Date:	11/17/2014
Priority:	Standard	Application Received:	12/15/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine Rehab, has a subspecialty in Interventional Spine, and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 59 year-old male with a 7/06/2009 date of injury. According to the 10/23/14 family practice report, the patient has chronic low back pain that radiates down the legs left greater than right; and has right knee pain. He has been diagnosed with lumbar discogenic syndrome/facet/spondylolisthesis; right knee meniscal tear with severe OA; myofascial pain; insomnia; left knee compensatory; lumbosacral radiculitis. The physician states he is awaiting follow-up with the ortho secondary to instability noted on flexion/extension radiographs. The physician requested a lumbar brace, heel cups and heating pads. On 11/17/14 utilization review denied the requests for: lumbar brace, using ODG guidelines; heel cups, stating there is no mention of heel pain or leg length discrepancy; and electric heating pad (because the patient already has one).

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Lumbar brace purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301; 308, TABLE 12-8. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back chapter for lumbar supports.

Decision rationale: The patient is reported to have lumbar spondylolisthesis with instability documented on flexion/extension radiographs and is awaiting approval for spinal orthopedic evaluation. The physician requested a lumbar support brace in the meantime. The patient is reported to not be working. ACOEM, chapter 12, Low Back, page 301: Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptoms relief ACOEM, chapter 12, Low Back, page 308, Table 12-8, "Summary of Evidence and Recommendations": Corsets for treatment - Not Recommended. In occupational setting, corset for prevention- Optional ODG guidelines, online, low back chapter for lumbar supports states: Treatment: Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, Regarding lumbar supports, the MTUS/ACOEM guidelines are opposite of the ODG guidelines. ACOEM does not recommend supports for treatment, but do recommend them for prevention. ODG guidelines state they are not recommended for prevention, but recommended for treatment, specifically for spondylolisthesis with documented instability as in this case. California Labor Code section 4610.5 for medical necessity, describes a hierarchy of review standards. According to this, the MTUS/ACOEM guidelines take precedence over ODG guidelines. MTUS/ACOEM states that corsets are not recommended for treatment, and they are only beneficial in the acute phase of care. The request for Lumbar brace purchase IS NOT medically necessary.

Heel cups purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308, TABLE 12-8. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Foot and Ankle section for Heel pads ODG Knee chapter, Footwear.

Decision rationale: The patient is reported to have lumbar spondylolisthesis with instability documented on flexion/extension radiographs and is awaiting approval for spinal orthopedic evaluation. There is also severe knee osteoarthritis and the patient is pending authorization for a total knee replacement. The treatment plan included heel cups. The medical report does not provide a rationale for heel cups. MTUS/ACOEM chapter 12, Low Back Complaints, page 308, table 12-8, states shoe lifts are not recommended, but shoe insoles are optional, but does not discuss heel cups. ODG online Foot and Ankle section for Heel pads state: Recommended as an option for plantar fasciitis, but not for Achilles tendonitis. ODG Knee chapter, for Footwear, knee arthritis states the mobility shoe does not contain lifts at the heel, which have been shown to increase knee loads, and its flexible sole is designed to mimic the flexible movement of a bare foot. The patient is not reported to have plantar fasciitis. There is knee arthritis and low back pain. ODG does not recommend heel lifts for knee arthritis as this increases the load on the knee. There is no provided rationale for the heel cups, and they do not appear to be recommended by ODG or ACOEM for the condition the patient is reported to have. The request for heel cup purchase IS NOT medically necessary.

Electric heating pad purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Outcomes and Endpoints Page(s): 9.

Decision rationale: The 10/23/14 medical report states the patient uses a TENS and heating pad daily, the in the treatment plan the physician requests another heating pad. There is no discussion of pain relief or improvement in function with the heating pad the patient already has. There is no discussion provided as to why the patient needs another heating pad. MTUS Chronic Pain Medical Treatment Guidelines, pg 9 under Pain Outcomes and Endpoints states: "All therapies are focused on the goal of functional restoration rather than merely the elimination of pain and assessment of treatment efficacy is accomplished by reporting functional improvement" There is no functional improvement reported with the use of the current heating pad,that would warrant purchase of another heating pad. MTUS does not recommend continued treatment without functional improvement. The request for the Electric heating pad purchase IS NOT medically necessary.